Website: kbn.ky.gov

# Kentucky Board of Nursing 312 Whittington Pky, Suite 300 Louisville, KY 40222-5172

## Instructions for the RN Licensure and ARNP Registration Application

Phone: 800-305-2042 or 502-429-3300

– Ge	General Information —						
	Licensure fees and regulatory requirements are subject to change.						
	Application fees are NON-REFUNDABLE:						
	RN Endorsement - \$150	☐ ARNP Endorseme	ent - \$150				
	RN Reinstatement - \$120	ARNP Reinstatem	ent - \$120				
	Validation of name change(s) is required if the name on any document received at KBN is different from the name on the application for licensure. Acceptable validations include a copy of either a:  1. Social security card, 2. Marriage license, <b>OR</b> 3. Court order or divorce decree showing the right to a name change.						
	You are required to notify KBN within	n 30 days of any name change.					
	You are required to notify KBN within 30 days of an address change. The notification must include:  1. Name 2. Social security number 3. Old address 4. New address						
	Complete all sections as indicated be	elow (see Section 2 for additional	information about the method of application):				
	Method of Application	Complete These Sections	<u>Submit</u>				
	RN Endorsement & ARNP Initial RN & ARNP Endorsement RN & ARNP Reinstatement	1, 2, 3, 4, 5, 6, 7, 8, 10, 12 1, 2, 3, 4, 5, 6, 7, 8, 10, 12 1, 2, 3, 4, 5, 6, 8, 9, 12	Either NurSys Form or Attachment 2 Either NurSys Form or Attachment 2 Attachment 1 (If Applicable)				
– Se	ection 1: Biographical [	)ata					
	All information must be provided.						
– Se	ection 2: Application T	vne ———					
	Darken the appropriate circle to indic	• •	endorsement or reinstatement.				
	☐ <b>Endorsement</b> : You have never	held a Kentucky nursing license of	or Kentucky ARNP registration.				
	<ul> <li>☐ Endorsement: You have never held a Kentucky nursing license or Kentucky ARNP registration.</li> <li>☐ Reinstatement: You held a Kentucky nursing license and Kentucky ARNP registration that have lapsed.</li> </ul>						
- Se	ection 3: Declaration o	f Permanent Resider	nce and Areas of Practice $-\!\!\!\!-$				
	Select your permanent state of residence and all jurisdictions in which you currently practice.						
	Evidence of permanent residence includes:  1. Copy of your voter's registration card. 2. Copy of driver's license.						
	Copy of federal income tax return  If you are not currently practicing put		y your permanent state of residence.				
	Do not submit evidence of permaner						
	Do not cubinit ovidence of permanent residence unless requested to do so.						
- Section 4: Answer ONLY if Employed in Kentucky as a RN or ARNP ———							
	DO NOT complete this section if you						

_ Section 5: Disciplinary ————————————————————————————————————
☐ All questions must be answered.
Failure to report any action pending or disciplinary action <b>EVER</b> taken on a nursing license may subject you to disciplinary action.
Failure to report participation in an alternative to discipline/diversion program may subject you to disciplinary action.
Section 6: Criminal History ————————————————————————————————————
☐ All questions must be answered.
☐ If you answered " <b>YES</b> " to any question(s), allow 3 months for all information to be reviewed by KBN.
Failure to report any criminal convictions <b>EVER</b> received may subject you to disciplinary action.
Section 7: Nursing Education —
List your initial program of nursing that is the basis of this application.
☐ Enter the month and year graduated from the initial program of nursing.
List your advanced practice nursing program.
☐ Enter the month and year graduated from the advanced practice nursing program.
A VisaScreen Certificate is required if your nursing education was outside of the U.S.A. For additional information, go to <a href="http://kbn.ky.gov/license/foreign.htm">http://kbn.ky.gov/license/foreign.htm</a> .
Section 8: ARNP Data
☐ Darken the appropriate circle to indicate your advanced practice designation.
☐ Darken the appropriate circle to indicate your certification/specialty type.
Darken the appropriate circle that indicates the national certifying organization to which you either belong or have applied to.
Indicate whether your national certification has ever been revoked or issued on a provisional status. If you answer "Yes" to this question, you must submit a detailed letter of explanation.
Section 9: Application for Reinstatement
1. The application is valid for one year from the date received at KBN.
<ul> <li>2. All applicants are required to provide proof of earning 3 hours of KBN approved domestic violence continuing education.</li> </ul>
<ul> <li>A list of approved courses will be found at http://kbn.ky.gov/education/ce/cecourses.htm.</li> </ul>
3. COMPETENCY VALIDATION: Choose ONE of the following methods that you wish to use to validate competency.
#1. 500 hours of employment as a nurse within 5 years of the date your application is received at KBN:
☐ Include a copy of an active nursing license.
Complete the top portion of Attachment 1 and send it to the employer for validation that you practiced 500 hours as a nurse.
☐ Have the employer mail or fax the completed form to KBN.
#2. Continuing Education:
If your Kentucky license lapsed within the past 5 years, contact the licensure specialist for information regarding the CE earnings that must be submitted.
Continuing education earned more than 5 years preceding the date your application is received at KBN will not be accepted.

<ul> <li>Section 9: Application for Licensure by Reinstatement (Continued)</li> </ul>
#3. If you have not practiced as a nurse 500 hours within 5 years of the date your application is received at KBN, you may submit <b>EITHER</b> :
<ul> <li>a. Refresher Course: Evidence of completing an approved refresher course within 2 years of the date your application is received at KBN.</li> <li>OR</li> </ul>
b. <b>120 Continuing Education Hours:</b> Evidence of earning 120 KBN approved continuing education hours within 1 year of the date your application was received at KBN.
#4. Copy of current certification/recertification card.
#5. A permanent Kentucky nursing license and Kentucky ARNP registration will be issued within 14 days of receipt of all requirements listed above.
<ul> <li>Section 10: Application for Licensure by Endorsement</li> </ul>
1. The application is valid for 6 months from the date received at KBN.
2. If you fail to complete all requirements within the 6-month period, you must submit another application,
fingerprint card, and pay the fees.
3. You are required to provide the following:
☐ #1. FINGERPRINT CARD:
You must complete a fingerprint card issued by KBN.
Complete the biographical data on the fingerprint card and take the card to any law enforcement agency in any state for the fingerprinting process.
Return the completed card to KBN with the \$24 processing fee.
☐ It may take 4-8 weeks for KBN to receive a report from the FBI.
Additional information can be found at <a href="http://kbn.ky.gov/license/endorse.htm">http://kbn.ky.gov/license/endorse.htm</a> .
☐ #2. NURSING EDUCATION:
<ul> <li>Official transcripts of <i>initial</i> nursing education are required of all applicants and must be sent directly from the program of nursing.</li> </ul>
Evidence of completion of <b>advanced practice</b> nursing education:
☐ 1. Applicants who completed post-basic ARNP education after January 1, 2005:
Must request your program of nursing to send KBN an official transcript with the degree and date posted.
<ul> <li>b. Must hold either a:</li> <li>◆ Masters degree, OR</li> <li>◆ Post-masters' certificate from a college or university awarding related ARNP credits.</li> </ul>
$\Box$ 2. Applicants who completed post-basic ARNP education prior to January 1, 2005:
<ul> <li>a. Nurse Practitioners and Clinical Nurse Specialists must request their advanced practice program of nursing to send KBN an official transcript with the degree and date posted.</li> </ul>
<ul> <li>b. Nurse Anesthetists and Nurse Midwives may submit a copy of:</li> <li>◆ Diploma,</li> <li>◆ Certificate of graduation, OR</li> <li>◆ Official transcript with degree and date posted.</li> </ul>
#3. COMPETENCY VALIDATION:
If you have been licensed as a RN GREATER THAN ONE YEAR, select one of the following:
☐ Being licensed within the past 5 years, <b>OR</b>

<ul><li>Section 10:</li></ul>	Application for Licensure by Endorsement (Continued) ——			
(cont.)	☐ Employment as a nurse for 500 hours within the past 5 years, <b>OR</b>			
	Employment as a nurse for at least 100 hours within the past 5 years [contact KBN licensure specialist for CE(s) requirements], <b>OR</b>			
	If you have not met one of the above validations of competency, you must provide proof of <b>EITHER</b> :			
	<ul> <li>a. Refresher Course: Evidence of completing an approved refresher course within 2 years of the date your application is received at KBN.</li> <li>OR</li> </ul>			
	b. 120 Continuing Education Hours: Evidence of earning 120 KBN approved continuing education hours within 1 year of the date your application was received at KBN.			
	If you have been licensed as a RN LESS THAN ONE YEAR:			
	An applicant who has not practiced as a RN in another state or territory for at least 120 hours within the first year following graduation from a program of nursing must complete a clinical internship.			
	☐ A provisional license may be issued within 14 days of receipt of the following:			
	<ul> <li>a. A completed Application for Licensure and the fee.</li> </ul>			
	<ul><li>□ b. A completed fingerprint card and the fee.</li></ul>			
	<ul> <li>c. An official transcript from your initial program of nursing with degree and date posted.</li> </ul>			
	☐ The clinical internship must be completed prior to the expiration date of the provisional license.			
	☐ The Verification of Completion of the Clinical Internship (VOC) form will be mailed with your provisional license.			
	☐ The VOC form must be completed and signed by both the RNA* and the supervising registered nurse and returned to KBN.			
	You may continue to practice as a RNA until:			
	<ul> <li>a. You are issued a permanent nursing license,</li> <li>b. The provisional license expires, OR</li> <li>c. You are unsuccessful on NCLEX.</li> </ul>			
	Practicing in Kentucky without a provisional license, temporary registration, or Kentucky nursing license may subject you to disciplinary action by KBN.			
	* RNA - Registered Nurse Applicant			
☐ #4.	HIV/AIDS CONTINUING EDUCATION:			
	☐ It is your responsibility to submit KBN proof of earning 2 hours of KBN approved HIV/AIDS continuing education.			
	☐ This CE may not be earned more than 2 years prior to the date the application is received at KBN.			
	A list of approved courses can be found at http://kbn.ky.gov/education/ce/cecourses.htm.			
□ #5.	VERIFICATION OF ORIGINAL LICENSURE:			
	☐ If your state of original licensure is listed on the NurSys Form, you must either:			
	<ul> <li>a. Complete the top portion of the form and send to the address as directed. OR</li> <li>b. Go to https://www.nursys.com/includes/processing?PSPartState/asp.</li> </ul>			

Section 10	: Application for Licensure by Endorsement (Continued) ———
	☐ If your state of original licensure is <b>NOT</b> listed on the NurSys form:
	a. Complete the top portion of Attachment 2.
	□ b. Send the form to your state of original licensure.
	☐ c. Contact the Board of Nursing in your original state of licensure for fee requirements.
□ #6	. TEMPORARY REGISTRATION (TR):
	☐ A TR may be issued within 14 days of receipt of the following:
	<ul> <li>a. A completed Application for Licensure and the fee.</li> </ul>
	□ b. A completed fingerprint card and the fee.
	<ul> <li>c. An official transcript from your RN and ARNP program of nursing with degree and date posted.</li> </ul>
	☐ d. Competency validation (if applicable).
	☐ The TR is valid for 6 months from the date issued and will not be extended.
	☐ If all requirements for licensure are not met before the TR expires, you must:
	$\square$ a. Reapply and pay the fee.
	☐ b. Submit a new fingerprint card and the fee.
	☐ Practicing without a valid TR, provisional license, or a Kentucky nursing license may subject
	you to disciplinary action by KBN.
□ #7	PERMANENT KENTUCKY LICENSE:
	If you were issued a TR, a permanent license will be issued upon receipt of:
	a. Verification of original licensure.
	□ b. Proof of earning 2 hours of KBN approved HIV/AIDS continuing education.
	c. Report from the FBI.
	If you were issued a PL, a permanent license will be issued upon receipt of:
	a. Verification of completion of the clinical internship (VOC).
	□ b. Verification of original licensure.
	c. Proof of earning 2 hours of KBN approved HIV/AIDS continuing education.
	☐ d. Report from the FBI.
	It is your responsibility to assure that all documents have been received by KBN BEFORE the application for licensure expires.
│ │	
│	Proof of earning 3 hours of KBN approved domestic violence continuing education must be
	earned within 3 years of the date you are issued a Kentucky nursing license.
	□ DO NOT SUBMIT PROOF OF EARNING THE DOMESTIC VIOLENCE CE UNLESS REQUESTED TO DO SO.
	A list of approved courses can be found at http://kbn.ky.gov/education/ce/cecourses.htm.
Section 11:	Responsibility & Accountability of Kentucky Licensed Nurses
	of nursing law cited in this section explains the accountability and responsibility of all nurses licensed to ing in Kentucky.
'	nursing laws and regulations may be found at http://kbn.ky.gov/laws.htm.

## Kentucky Board of Nursing 312 Whittington Pky, Suite 300 Louisville, KY 40222-5172

502-429-3300 or 800-305-2042

## **APPLICATION FOR RN LICENSURE** AND ARNP REGISTRATION

Office Use Only -

A4 - EN & FP A5 - EN

A7 - RS

#### Refer to instruction sheet before completing this application. APPLICATION FEE IS NON-REFUNDABLE & SUBJECT TO CHANGE

Print clearly using capital letters and black ink.

Section 1. Biographical Data															
Last Name															
First Name									_	Middle	Name				
Maiden Na	me														
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Social S	ecurity#				Da	ate o	f Birth		_						
							] - [_					U.	S. Citizen	? Yes	No (
Address Li	ne 1								$\overline{}$						
Address Li	ne 2														
City	'		1			1		1				<u> </u>	State	Zip	
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- Section	2: Applic	ration 1	Tyne —												
Scotion	ız. Applic	Jation	ypc						Make c	heck or	money o	order pa	yable to th	ie Kentucky B	oard of Nursing
┌ If You	Have Neve	r Held a	Kentuc	ky Nurs	ing Li	cense			-					0	
RNI	Endorseme	ent & AR	NP End	lorseme	nt (A4	)					3, 4, 5,			int Card Fee	
If Vo.:	Held a Ker	ntucky N	ureina l	licanec	and a	n ADN	ND Par	ietrati							
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RN Reinstatement & ARNP Reinstatement (A7)  Complete Sections 1, 2, 3, 4, 5, 7, 8, 9, 12															
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	3: Decla			_			e and								
List your primary state of residence: KY Other Do not submit evidence of primary residence unless requested to do so.															
Jurisdictions in which you currently practice (circle ALL that apply):															
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Section 4: Answer Only if you are Employed in KY as a RN or ARNP						
Date of Kentucky Employment: Employed as: RN ARNP						
Employer						
		Employar's Telephone #				
City		Employer's Telephone #				
Section 5: Disciplinary						
If you answer "yes" to any of these questions, your ap  1. Submit a detailed letter of explanation for ex		ocessed until the following documents are received:  2. Attach a certified copy of the Board's action.				
·		2. Auton a common copy of the Board o action.				
Darken the appropriate circle and print in the box	es provided below.	If yes, list STATE and YEAR If yes, list STATE and YEAR				
Have you ever been denied a nursing license? (For reasons other than failure to pass State Board Exam/NCLEX)	Yes O No O					
Have you ever had any disciplinary action on your nursing license or your privilege to practice nursing in any state(s)?	Yes O No O					
Do you have disciplinary action or a complaint pending on your nursing license or your privilege to practice in any state(s)?	Yes O No O					
Are you currently a participant in a state board/designee monitoring program including alternative to discipline, diversion, or a peer assistance program?	Yes O No O					
Section 6: Criminal History						
You must REPORT:		Your application will not be processed until you <b>SUBMIT</b> the required documents listed below.				
1. All felony convictions ever received		Certified Court Documents & Detailed Letter of Explanation				
2. All misdemeanor(s) received within 5 years of the	date of application	Certified Court Documents & Detailed Letter of Explanation				
3. All DUIs		Certified Court Documents & Detailed Letter of Explanation				
4. All misdemeanor(s) received prior to 5 years of the	e date of application	No Documents Required				
Note: Traffic violations OTHER than DUIs do not need to be reported.						
		If yes, list STATE and YEAR If yes, list STATE and YEAR				
Have you ever been convicted of a misdemeanor(s)?	Yes O No O					
Type of conviction:		- -				
Have you ever been convicted of a felony(s)?	Yes ∩ No ∩	If yes, list STATE and YEAR If yes, list STATE and YEAR				
	0 0	d any misdemeanors or felonies?				
Since you last applied for or were issued a KY nursin	y iicerise, riave you na	d any misdemeanors or felonies? Yes () No ()				

Section 7: Nursing Education						
List the name of the program of nursing of initial nursing education.						
City	State	Country (If Not U.S.A.)				
Month & Year Graduated Type Nu	ırsing Program:					
- RN Diplo	oma O ADN/AAS O BSN O	Other List Type				
<b>Advanced Practice Nursing Program:</b>						
		RN -				
City		State ARNP-				
Month & Year Graduated						
	ree Earned:					
	ed outside of the U.S.A., you must obtain a Vis					
additional information.	sa outside of the o.o.A., you must obtain a vis	sacoreen certinoate. See mandonons for				
Cookies O. ADND Dete						
Section 8: ARNP Data						
Advanced Practice Designation:	Anesthetist (3) Midwife (4) Nurse	Practitioner (5) Clinical Specialist (6)				
Select Specialty Type Below:						
O	6. Women's Health	12. Acute Care				
1. Anesthetist	7. Gerontological	13. Community Health				
2. Midwife	8. School	14. Critical Care				
3. Adult	9. Adult Psy/Mental Health	15. Oncology				
○ 4. Family	10. Child/Adol Psy/Mental Health	16. Family Psy/Mental Health				
5. Pediatric	11. Neonatal					
O 3. I culture	0					
National Certification Organization:	You must enclose a copy of your current cer	rtification card.				
American Assn of Nurse Anesthetists	American Midwifery Certification Board	Oncology Nursing Certification Corp				
American Assn of Colleges of Nursing	American Nurses Credentialing Center	Pediatric Nursing Certification Board				
American Academy of Nurse Practitioner	ers National Certification Corporation	S				
Have you been registered certified or li	censed for at least one year prior to filing this appli	cation? Yes () No ()				
-						
Has your national certification ever been revoked or issued on a provisional/conditional status?  Yes No O  If yes, submit a detailed letter of explanation.						
	The second of th	L'Itan Oran Vara N				
• •	sure by Reinstatement of RN and ARNP (Va	liia for Une Year) ————————————————————————————————————				
Select ONE of the following:	the west Foreign as DN1					
I have practiced 500 hours within the past 5 years as a RN in another state.  You must submit:						
■ Verification of employment (Attachment 1); AND						
	rsing license from that state; AND					
^	ours of KBN approved domestic violence continuing	g education.				
I have NOT practiced 500 hours v You must submit:	vithin the past 5 years as a RN.					
	proved continuing education hours, earned within	1 year of the date of application: OR				
	pproved refresher course, earned within 2 years of					
<ul> <li>Proof of earning 3 contact ho</li> </ul>	ours of KBN approved domestic violence continuing	g education.				
My Kentucky nursing license I requirements.	apsed within the past 5 years. Contact the	ARNP licensure specialist for specific				

— Section 10: Application for Licensure by Endorsement for RN and ARNP - Valid for 6 Months ————————————————————————————————————							
State & Year of Original Licensure as RN  Refer to the instruction sheet for additional requirements if your nursing education was not							
If you hold a current active license, choose ONE of the following: received in a U.S. jurisdiction.							
O I have been licensed as a RN less than 5 years.							
I have practiced 500 hours as a RN within the last 5 years.							
I have not practiced 500 hours as a RN in the last 5 years but have been licensed in another state longer than 5 years.  Contact KBN for requirements.							
Applicants for endorsement must submit:							
A fingerprint card issued by KBN.							
2. Verification of original licensure. NurSys Form or Attachment 2							
3. Evidence of having earned 2 contact hours of KBN approved HIV/AIDS education. Contact hours must not be earned more than 2 years prior to date of application.							
4. A transcript of basic nursing education and advanced practice education.							
5. A copy of a current active nursing license.							
Provide the following information regarding your last two employers:							
Name of Employer 1							
Address							
City State Zip							
Length of Employment							
Name of Employer 2							
City State Zip							
Telephone #							
Length of Employment							
Comparison Section 11: Responsibility and Accountability of Kentucky Licensed Nurses							
KRS 314.021(2): All individuals licensed under provisions of this chapter shall be responsible and accountable for making decisions that are based							
upon the individual's educational preparation and experience in nursing and shall practice nursing with reasonable skill and safety.							
Section 12: Attestation Statement							
I certify that I am the person referred to in the foregoing application for RN licensure and ARNP registration in the Commonwealth of Kentucky; that I am not in default of a student loan administered by the Kentucky Higher Education Assistance Authority (KHEAA), that I am not delinquent in the							
repayment of a defaulted Nursing Incentive Scholarship Fund award administered by KBN, that all statements contained herein and on all							
attachments are true and correct in every respect; and that I have read and understand this application and all requirements stated therein. I further understand that all information on this application is subject to an audit for verification and that the falsification of any information contained herein							
will be cause for disciplinary action. I declare my primary state of residence to be the state as indicated in Section 3 of this application.							
Applicant's Signature							
Applicant's Signature ————————————————————————————————————							
- Office Use Only							
HIV/AIDS in PON: 2/2006							



Kentucky Board of Nursing 312 Whittington Pky, Suite 300 Louisville, KY 40222-5172

502-429-3300 or 800-305-2042

#### Fax: 502-429-3311

### **VERIFICATION OF EMPLOYMENT**

**ATTACHMENT 1** 

Complete this form only if you are reinstating your RN/LPN Kentucky license.

6/2006

To the Applicant					
Complete this section of the Verification of Employment form. In that you practiced as a nurse 500 hours during the past five years. The Third Control of the Verification of Employment form.					
TO THE KENTUCKY BOARD OF NURSING.  Applicant's Last Name:					
Applicant's Last Name.					
Applicant's First Name:					
Applicant's riist Name.					
Social Security #: Year of Graduation From Basic I	PON:				
	Employed As: RN LPN				
Employing Facility:					
Facility's Address:					
City:	State: Zip:				
Facility's Phone #: Employed From (Mo					
To the Complexes /Drawiers Complexes					
To the Employer/Previous Employer ————————————————————————————————————					
Complete this section of the Verification of Employment form, an KENTUCKY BOARD OF NURSING.	nd MAIL OR FAX THIS FORM DIRECTLY TO THE				
Has the above named individual been engaged in active nursing pract	ice for at least 500 hours during the past five years				
	ours of practice:				
,	·				
Facility Name	······································				
Employer's Name (Please Print)  Title & Phone #					
Employer's Signature	Date				
Office Use Only					
Person Contacted at Above Facility:	Employment Verified? If no, explanation rec'd:				
Title of Person Contacted:					
Date & Time Contacted:					



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Phone: 502-429-3300 or 800-305-2042 Fax: 502-429-3311

#### **VERIFICATION OF LICENSURE**

**ATTACHMENT 2** 

Complete this form only if you are endorsing a nursing license from another state.

- To the Applicant					
Complete this section and send to the Board of Nursing in the state where you received your original license.  Contact your original state of licensure for fee requirements.					
NOTE: Be sure to check the states listed on the NurSys Form to					
determine if you should complete this attachment or the NurSys Form.					
Last Name:					
Middle Name: Maiden Name:					
Street:					
City: State: Zip:					
Social Security #: License #: Date of Birth:					
To Be Completed by the Board of Nursing in the State of Original Licensure					
To be completed by the board of harsing in the state of original Elections					
Licensed in the State of: By Endorsement By Examination					
License Type Issued: RN LPN Date of Original License: Month Year					
Name of Nursing Program (PON):					
City of PON: State of PON:					
Type of Program: O Vocational RN Diploma ADN/AAS BSN Masters Other					
Date of Completion:    Month   Year   Is/Was this an approved program?   Yes   No					
Has this license ever been revoked, suspended, restricted, limited, probated, or otherwise disciplined?					
Is there any action pending on this license or privilege to practice? Yes No If yes, submit a certified copy of the Board's action.					
Is or has this licensee ever been a participant in a state board/designee monitoring program including alternative to discipline, diversion, or a peer assistance program? Yes No					
Did this individual take and pass either the State Board Test Pool Examination (SBTPE) or the National Council Licensure Examination (NCLEX)?   Yes Series #: No If no, please explain					
I certify that the above information accurately represents the information on file with the Board.					
Signed and the Board seal affixed on this date:					
Signature					
Title 6/2006					

# VERIFICATION OF SUPERVISION FOR ADVANCED REGISTERED NURSE PRACTITIONER (ARNP) APPLICANT

ARNP Applicant						
Complete this section only and forward this form to your prospective employer. The prospective employer must mail this form to the attention of the "ARNP Licensure Specialist" at the Kentucky Board of Nursing. The address is provided at the top of this form.						
ARNP Applicant's Last Name:						
ARNP Applicant's First Name:						
Advanced Practice Designation: Anesthetist F	Practitioner					
Employing Facility:						
Facility's Address:						
City:	State: Zip:					
Facility's Phone #: Antic	cipated Date of Employment:					
Employment Position:						
To be Completed by the Prospective Employer ————————————————————————————————————						
By signing this form, you are attesting that the applicant for ARNP registration listed above will be practicing under your supervision* until the applicant is issued a permanent ARNP registration by the Kentucky Board of Nursing. Only an ARNP of the same specialty or a licensed physician may supervise an applicant for ARNP registration. All individuals providing supervision must sign this form in the spaces provided or on the attached sheet.						
Return this form to the attention of the "ARNP Licensure Specialist" at the Kentucky Board of Nursing. The address is provided at the top of this form.						
* Supervision is defined in KAR 20:056, Section 4(1)(b) as periodic observation and evaluation of the applicant's practice to validate that the practice has been performed according to established standards. The supervisor shall be immediately available either on site or by telephone.						
I hereby agree to provide the required supervision to the above named applicant for ARNP registration:						
Supervising ARNP Supervising Physician						
Signature Date	Signature Date					
KY RN License # ARNP #	KY License #					

Space for additional signatures is provided on the attached sheet, if needed.

- apo. 1.0g / 1.1.11		Supervising Physician -	
ignature	 Date	Signature	 Date
KY RN License #	ARNP#	KY License #	
Supervising ARNP -		Supervising Physician -	
Signature	Date	Signature	Date
KY RN License #	ARNP #	KY License #	
Supervising ARNP -		Supervising Physician	
Signature		Signature	Date
KY RN License #	ARNP#	KY License #	
Supervising ARNP -		Supervising Physician -	
Signature		Signature	Date
KY RN License #	ARNP #	KY License #	
Supervising ARNP -		Supervising Physician -	
Signature	Date	Signature	Date

### **VERIFICATION OF ELIGIBILITY FOR NATIONAL CERTIFICATION**

Complete this form ONLY if you do not hold current national certification.

- Candidate					
Complete this section only and forward to the national certification or Contact the national certification organization regarding any fees that may be re-					
The national certification organization must mail this form to the attention the Kentucky Board of Nursing. The address is provided at the top of the form					
Candidate's Last Name:					
Candidate's First Name:					
Advanced Practice Designation: Anesthetist Practitioner	) Midwife				
National Certification Organization:					
Please release my test results to the Kentucky Board of Nursing.					
Signature —	Date:				
To be Completed by the National Certification Organization					
Complete this portion of the Verification of Eligibility for National Certification form and return to the attention of the "ARNP Licensure Specialist" at the Kentucky Board of Nursing. The address is provided at the top of this form.					
For additional information, contact the ARNP Licensure Specialist at 502-429-3					
Examination Information					
First-Time Candidate or Repeat Candidate					
Scheduled to Take Exam or Eligible to Take Exam Beginning					
Through					
Tillough					
─ Verification Statement — — — — — — — — — — — — — — — — — — —					
This is to verify that the candidate listed above has met eligibility requirements and has applied to take the					
examination for certification for advanced practice nursing.	unements and has applied to take the				
Name:	S E A L				
Title:	_				
Organization's Phone #: Ext:					
Date:	6/2006				